Fluence Clinic

Patient: **Nathan Rashleigh**

Age: **34**

D.O.B: **10.05.1989**

Address: **1 Hay Street**
Preston
VIC 3072

Mobile: **0433 034 004**

Referrer: **Dr Stefan Panczak**
reception@turnthecorner.com.au

Date of assessment: 17.04.2024

Psychiatry 291 Assessment

Dear Dr Stefan Panczak,

Thank you for your comprehensive referral of Nathan Rashleigh for a diagnostic assessment of possible ADHD. I reviewed Nathan via telehealth on the 17.04.2024. Nathan presented well and engaged in the interview.

Nathan is a 34-year-old male living alone, in a new relationship and working as a computer programmer. He is looking for new jobs. He has had extensive psychometric assessments by his psychologist.

During the assessment, he faced challenges related to maintaining focus in his home life and struggled more with his ability to perform tasks both at home and at work, as well as with task initiation. He also struggled with time blindness, finding it hard to do tasks that are uninteresting and unimportant. He described himself as always busy and feeling like he has multiple tabs open in his mind. He tends to hyperfocus on tasks and struggles with procrastination but feels constantly on the go. Additionally, he finds himself lacking a routine, controlling fidgeting, making decisions regarding task initiation, and organizing tasks in both personal and professional life. These challenges manifest particularly daily, where procrastination is common, and also impact his personal life, leading to significant distractions and memory difficulties.

Throughout the assessment, there were no indications of psychotic symptoms, and Nathan denied experiencing auditory, olfactory, or visual hallucinations. There was no evidence of an idea of reference, passivity phenomena, or manic symptoms. He did not exhibit obsessional or compulsive

symptoms, and there was no recent history of self-harm or current thoughts of harming himself or others. There were no overt depressive symptoms of note, and there were no current anxiety symptoms.

Medications:

NIL.

Allergies:

There are no known drug allergies.

Substance Use History:

He does not drink alcohol unless socially, he does not smoke cigarettes, and he does not use any substances.

Forensic History:

He has had no forensic issues.

Developmental History:

Nathan was born in Brisbane. He is the eldest of 2 children. His parents ran a building materials company. His sister is working in the film industry. He got an OP5 and went into university in Year 12. He completed university in 4 years.

Past Psychiatric History:

Nil known.

Physical Health History:

Nathan denies any cardiac or neurological issues, and there is no history of epilepsy.

Family History:

NIL.

Mental State Examination:

During the telehealth session, he wore a grey top, used headphones, and looked younger than his stated age. His rapport was easy to establish, and his speech was of a normal rate, rhythm, and

volume. No perceptual abnormalities were observed. He was constantly fidgeting. Nathan did not express any suicidal or homicidal thoughts. His mood was euthymic, congruent, and reactive, with good insight and cognition. Although formal testing was not conducted, his cognition appeared within normal limits.

Psychometric assessments: ADHD ASRS

ADHD-RS with Adult Prompts

DIVA

Inattentive ADHD - Childhood: 9

Inattentive ADHD - Adulthood: 9

Hyperactivity/impulsivity Childhood: 5

Hyperactivity/impulsivity Adulthood: 7

Becks depression inventory: 25

Becks anxiety inventory: 16

BASC-3

BEDS

Q-LES-Q-S

ACE: 1

Risk Assessment:

The current risk of self-harm and suicide is deemed low, with a similar low risk to others. He has the capacity to make decisions regarding his assessment and treatment. Nathan maintains a future-focused perspective.

Diagnostic Impression:

Nathan meets the criteria for ADHD, inattentive type, with symptoms present in the early developmental period with anxiety symptoms.

Recommendations and Plan:

I. Attention Deficit Hyperactivity Disorder:

1. Nathan will benefit from initially starting stimulant-based medication to help with his ADHD. I support his GP Dr Stefan Panczak obtaining a Schedule 8 Permit for any ADHD stimulant as tolerated.

2. Please consider either initiating Ritalin IR in the interim, starting at 5-10mg once daily in the morning, and then 5-10mg midday. If needed, 5-10mg at 1400 can be added, and after 4 weeks, if this works well, we can then switch to Ritalin LA which can be increased to 60mg daily. This can be increased every 2 weeks by 10mg to a maximum of 40mg. If the Ritalin LA trial yields no positive outcomes, discontinuation is advised, followed by the initiation of Vyvanse at 20mg, with the possibility of increasing the dose by 10mg every fortnight, up to 70mg if necessary. We can either start Ritalin or Dexamphetamine as a first line. If starting Dexamphetamine 5-10mg once daily in the morning, midday, and at 1400, and we can use this as a top-up if needed to a maximum of 40mg. We ideally would like to move to long-acting medications within 8-12 weeks.

3. We recommend taking medications on weekdays (workdays), with weekends designated as rest days, as drug holidays are useful for maintaining the lowest effective dose.

4. We discussed the red flags associated with stimulants, including psychosis and mania, and the increased risk of seizures, along with the heightened risks of hypertension and heightened anxiety.

5. If disrupted sleep, escalating psychomotor agitation, or worsening anxiety occur, Nathan should discontinue stimulants and consider starting atomoxetine at 10mg, increasing it to 25mg after six weeks. This can be increased in six weeks to 40mg and then finally to 80mg. If we are discontinuing atomoxetine, please contact us for guidance. If significant improvement is not observed following these trials, please refer Nathan back to our care.

6. I have suggested that he have a baseline ECG and routine bloods. Please monitor his vitals at baseline and on a regular basis and for random urine drug screens before script refills. Please keep a copy of the schedule 8 when driving.

7. Please monitor Nathan's sleep hygiene practices. Please start clonidine to help with his poor sleep at 100mcg and increase by 50-100mcg along with melatonin 5mg nocte daily. If not, we can try Lemborexant 5mg mane to aid with insomnia. (When using Clonidine, please monitor his blood pressure.)

8. Please monitor for serotonin syndrome in the future and refer for ongoing psychological therapies under an MHCP.

Please do not hesitate to contact me if you have any questions or require additional information.

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Thank you for referring Nathan to our care. I will review him in 12 months or earlier if necessary.

Yours sincerely,



Dr Murugesh Nidyananda
Psychiatrist, FRANZCP CERT CAP

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Patient Information

For individuals with Attention Deficit Hyperactivity Disorder (ADHD), medication is one of the treatment options, but it's not the only approach. Here's some information on both medication and non-medication approaches that can be beneficial:

Attention Deficit Hyperactivity Disorder (ADHD):

ADHD is a neurodevelopmental disorder that affects both children and adults. The core symptoms of ADHD include inattention, hyperactivity, and impulsivity. However, it's important to note that ADHD presents differently in each individual, and not everyone will experience all of these symptoms.

Non-medication approaches for managing ADHD include:

1. Behavioural therapy: This involves teaching individuals strategies and skills to manage their symptoms, improve focus, and develop better organizational skills. Behavioural therapy can be highly effective for children and adults alike.

2. Cognitive-behavioural therapy (CBT): CBT can help individuals identify negative thought patterns and develop coping mechanisms to manage their symptoms and improve daily functioning.

3. Family training and education: For individuals with ADHD, educating loved ones about the condition and providing them with strategies to support their loved one's needs can be beneficial.

4. Occupational therapy: Occupational therapists can work with individuals to develop strategies for managing daily tasks, time management, and sensory sensitivities.

5. Exercise and physical activity: Regular physical exercise can be an effective way to reduce hyperactivity and improve focus in individuals with ADHD.

6. Mindfulness and relaxation techniques: Practices like mindfulness and deep breathing exercises can help manage impulsivity and promote emotional regulation.

Please find some self-help resources for ADHD:

Books:

1. ADHD 2.0, New Science and Essential Strategies for Thriving with Distraction:
   From Childhood Through to Adulthood. Edward.H.Hallowell M.D. and John.J.Rakey. M.D.

Apps:

1. Brain Focus – Pomodoro task management tool.

2. Simple Mind Pro – Mind mapping.

3. Remember the Milk – to reduce ‘overwhelm’.

4. Due – reminders and timers.

YouTube channels:

1. Russell Barkley ADHD
   ‘How to ADHD’

2. What is ADHD?
   Part 1

   https://www.youtube.com/watch?v=NIpFmDr72Uo&pp=ygUbUnVzc2xlIGJhcmtsZXkgd2hhdCBpcyBhZGhk

   Part 2
   https://youtu.be/miEeMlnPkQA

3. How to treat ADHD
   https://www.youtube.com/watch?v=_tpB-B8BXk0&t=9s&pp=ygUbUnVzc2